myocardium which result in myocardial infarction. Thus myocardial infarction can occur in the absence of coronary occlusion if coronary insufficiency is protracted enough. This fact has been well substantiated by the experiments of Blumgart and his co-workers. Likewise, coronary occlusion may occur without myocardial infarction if the collateral circulation from other coronary arteries is sufficiently adequate to prevent coronary insufficiency.

Coronary insufficiency can be recognized by either the appearance of angina pectoris, myocardial infarction, or by the presence of characteristic ECG findings. The last may be present in the absence of symptoms but must be cautiously interpreted. The development of intraventricular block while the patient is being observed, or the presence of typical Q waves, ST segment contours, and T wave changes in combination are necessary for an unequivocal diagnosis of coronary insufficiency from the ECG alone. The use of unipolar exploring leads is expanding the usefulness of the ECG as a diagnostic tool in these cases.

In doubtful cases, acute transitory coronary insufficiency may be precipitated by various means such as inhalation of 10 per cent oxygen, epinephrine, or a moderate exercise test. Levy has investigated the effects of myocardial hypoxia induced by the inhalation of 10 per cent oxygen and his publications cite criteria for an abnormal response. However, the necessity for specialized equipment and reported serious effects from the procedure indicate that this method is not practical for ordinary clinical use. Epinephrine has produced myocardial infarction and also is not recommended. Exercise is the safest and most easily available method of inducing coronary insufficiency and a recent study with adequate controls has been published by Twiss and Sokolow. These authors define the criteria for an abnormal ECG response to exercise. Needless to emphasize, careful observation of the patient during the exercise test adds much to the value of the procedure.

It is felt that the concept of functional coronary insufficiency as contrasted to organic coronary disease will be of considerable aid in understanding the symptoms and clinical course of patients with this pathophysiologic disturbance.

Public Relations and Medicine

Public relations, like medical practice, often suffers from a lack or an ambiguity of definitions. Unlike those in medical practice, terms in public relations cannot be pinned down to specificity in some respects by the addition of a prefix or suffix.

Get ten public relations professionals together and you will get ten definitions as to what public relations is. One authority wrote a book on the subject and completed 360 printed pages with the conclusion that he could not define the field.

At a recent medical meeting where this topic was under discussion, the speaker admitted his inability to define the term but he did give the two requisites of a public relations program. First, he said, you must "be good or do good." Second, you must "tell about it."

The medical profession of California has long been interested in the creation of better public relations, in a better public understanding of the profession's aims and attitude. The need has been pointed up by attacks made on the profession by various lay critics, including a not inconsiderable number of highly placed politicians. The climax has come in the demand for a system of public medical care under the guise of an insurance program with compulsory features either admitted or implied throughout many legislative proposals.

In reply to this need for public relations, California medicine has employed public relations counsel and has gone before the public with a long and costly campaign. It has brought out the weak points, the impossible provisions, of legislative proposals which would wreck sound medical practice in the effort to improve the spread of medical care. It has carried the message to the public and to the legislators. It has worked concurrently to advance as rapidly and as soundly as possible the availability of a substantial program of medical cost prepayment through medicine's own organization, California Physicians' Service.

There have been critics of this program, and even some who profess an ability to do the job better. Doubtless there have been errors in the commission of the numerous details which enter into the fulfillment of a campaign of such magnitude. All in all, however, it must be recognized that progress has been made and that medicine stands higher in public esteem today in this state than it did two years ago. The very paucity of newspaper headlines concerning present proposals for compulsory health insurance argues in this direction.

The campaign for the past two years has been of the "tell about it" nature. It has not had time to concern itself with the "be good or do good" side of public relations. Now, with the sting taken out of public disapproval, it may well be time to take stock of the current situation and to consolidate the gains already made. It may well be time to plan a campaign improving the plant by looking to the well-being of the roots.

There are those in every profession, a minority to be sure, who bring discredit which can outweigh the good done by the majority. There are those in our profession who engage in practices which reflect discredit, not always through thoughtlessness. There are doubtless a few who take deliberate advantage of the public and whose practices present a problem of control that may well demand police powers.

The existence of these factors indicates the need of a self-inspection and improvement. Continued education is one approach, founded upon factors both ethical and scientific. Spectacular measures may or may not be necessary; routine procedures can certainly be evolved to help much of the problem. And that "look into the mirror" ought to produce results.

Despite some unavoidable failures or faults, the C.M.A. has undoubtedly done a good job in the past two years in looking out for the "tell about it" side of public relations. This work should be continued, at least to the extent necessary to maintain the position already gained. We must now take a closer look at the aspect of improved professional work and better ethics.

Compulsory Government Health Service*

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Our present system of medical service gives better *average* medical care than any other system in the world. That does not permit us to ignore the fact that under it many people below the average do not get adequate medical care. Doctors and dentists and hospitals and health insurance companies exist for the benefit of the sick, not the reverse. Therefore, they must take a more active lead in making better care possible for the quarter of our population who do not have it, while retaining the essentials of the system which has done so well for the three-quarters—or else action will be taken by political groups which in the long run will not be good for either the patient or those who provide medical care.

Present proposals for universal governmental control of medical service would lead to the evils of compulsion and concentration of power in an inevitably huge and sprawling bureaucracy. Why should any be so naive as to believe it would be more efficient and less dictatorial than other bureaus have been? Power feeds on power. Power also always corrupts.

The greatest evil is the regimentation and inferior grade of medical care which will inevitably result in a system which gives essentially the same rewards to the competent and the incompetent. It tends to hold down the former and hold up the latter. When the doctor or dentist gets paid by the government, then he works for the government, not the patient. There may be more equitable distribution of such care as there is, but such care as there is in most cases will steadily deteriorate—as any person who has dealt with government medicine in the Army and Navy, or most veterans' hospitals or state institutions can testify.

Doctors and dentists and private insurance companies must experiment boldly with various plans in individual cities, counties, and states, until we can work out voluntary insurance systems on a sound actuarial basis which will bring the advantages of better distribution without deterioration of quality. Much progress is already being made in this direction—in California, Michigan, Minnesota, etc.

We must also do a better job of selling to the public the dangers to them of government controlled medical service. The public has been told what that system would allegedly give. It has not realized what it will take away. But doctors know. The dangers in the proposals are not to the doctors, but to the public, i.e. to the sick.

Government allowances for the permanently disabled or infirm or aged are of course wholly to be approved. Also provision for all who may be temporarily unable to pay for necessary service.

The answer is to be found in formation of private medical insurance and sick and accident benefit organizations. They ought to be operated under private enterprise and not by government bureaus which would promptly yield to the temptation to make a partisan political instrument of federal socialized medicine.

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* Abstract of informal remarks before officers of the California Medical Association, San Francisco, February 12, 1947.